		FOR OHF USE					

LL1

2002
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2002)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0026716

Facility Name: Robings Manor Nursing Home

Address: 502 North Main Street (Number) Brighton (City) 62012 (Zip Code)

County: Macoupin

Telephone Number: (618) 372-3232 **Fax #** (618) 372-7117

IDPA ID Number: 371068286004

Date of Initial License for Current Owners: 01/01/77

Type of Ownership:

	VOLUNTARY,NON-PROFIT		X	PROPRIETARY		GOVERNMENTAL	
		Charitable Corp.			Individual		State
		Trust			Partnership		County
IRS Exemption Code					Corporation		Other
				X	"Sub-S" Corp.		
					Limited Liability Co.		
					Trust		
					Other		

In the event there are further questions about this report, please contact:
Name: Christine A. Hanover **Telephone Number:** (312) 634-3400
Please send copies of desk review and audit adjustments to address on this page

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/02 to 12/31/02 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider	(Signed)	(Date)
	(Type or Print Name)	
	(Title)	
Paid Preparer	(Signed)	SEE ACCOUNTANTS' COMPILATION REPORT (Date)
	(Print Name and Title)	
	(Firm Name & Address)	Altschuler, Melvoin and Glasser LLP One South Wacker Drive, Suite 800, Chicago, IL 60606
	(Telephone)	(312) 634-3400 Fax # (312) 634-5518

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 **Phone # (217) 782-1630**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Robings Manor Nursing Home # 0026716 Report Period Beginning: 01/01/02 Ending: 12/31/02

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds N/A

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	25	Skilled (SNF)	25	9,125	1
2		Skilled Pediatric (SNF/PED)			2
3	43	Intermediate (ICF)	43	15,695	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	68	TOTALS	68	24,820	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF			1,332	1,332	8
9	SNF/PED					9
10	ICF	16,782	5,487		22,269	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	16,782	5,487	1,332	23,601	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 95.09%

D. How many bed-hold days during this year were paid by Public Aid?
129 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
None

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [X] NO [ ] Non-allowable costs have been eliminated in Schedule V, Column 7.

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 01/01/77

J. Was the facility purchased or leased after January 1, 1978?
YES [ ] Date NO [X]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 25 and days of care provided 1,332

Medicare Intermediary AdminaStar Federal, Inc.

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [x] NO [ ]

Tax Year: 12/31/02 Fiscal Year: 12/31/02

* All facilities other than governmental must report on the accrual basis.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Robings Manor Nursing Home # 0026716 Report Period Beginning: 01/01/02 Ending: 12/31/02

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger Salary/Wage 1	Supplies 2	Other 3	Total 4	Reclass-ification 5	Reclassified Total 6	Adjust-ments 7**	Adjusted Total 8	FOR OHF USE ONLY 9	10	
	A. General Services											
1	Dietary	85,387	10,652		96,039		96,039		96,039			1
2	Food Purchase		87,939		87,939		87,939	(2,903)	85,036			2
3	Housekeeping	54,738	9,528		64,266		64,266		64,266			3
4	Laundry	32,268	6,565		38,833		38,833		38,833			4
5	Heat and Other Utilities			42,839	42,839		42,839	397	43,236			5
6	Maintenance	24,618	28,965	66	53,649		53,649	707	54,356			6
7	Other (specify):*											7
8	**TOTAL General Services**	197,011	143,649	42,905	383,565		383,565	(1,799)	381,766			8
	B. Health Care and Programs											
9	Medical Director			7,800	7,800		7,800		7,800			9
10	Nursing and Medical Records	584,281	20,919	825	606,025		606,025		606,025			10
10a	Therapy			171,708	171,708		171,708		171,708			10a
11	Activities	16,488	2,651		19,139		19,139		19,139			11
12	Social Services	29,940	346	375	30,661		30,661		30,661			12
13	Nurse Aide Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	630,709	23,916	180,708	835,333		835,333		835,333			16
	C. General Administration											
17	Administrative	117,937		39,181	157,118		157,118	(39,181)	117,937			17
18	Directors Fees											18
19	Professional Services			18,744	18,744		18,744	8,690	27,434			19
20	Dues, Fees, Subscriptions & Promotions			3,331	3,331		3,331	531	3,862			20
21	Clerical & General Office Expenses	24,841	4,967	12,778	42,586		42,586	11,926	54,512			21
22	Employee Benefits & Payroll Taxes			138,548	138,548		138,548	13,604	152,152			22
23	Inservice Training & Education			65	65		65	441	506			23
24	Travel and Seminar			8,273	8,273		8,273	1,112	9,385			24
25	Other Admin. Staff Transportation			2,616	2,616		2,616	1,045	3,661			25
26	Insurance-Prop.Liab.Malpractice			35,353	35,353		35,353	1,600	36,953			26
27	Other (specify):*											27
28	**TOTAL General Administration**	142,778	4,967	258,889	406,634		406,634	(232)	406,402			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	970,498	172,532	482,502	1,625,532		1,625,532	(2,031)	1,623,501			29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.

SEE ACCOUNTANTS' COMPILATION REPORT

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

**See schedule of adjustments attached at end of cost report.

Facility Name & ID Number Robings Manor Nursing Home #0026716 Report Period Beginning: 01/01/02 Ending: 12/31/02

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7**	8	9	10	
30	Depreciation			37,812	37,812		37,812	5,227	43,039			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			122,599	122,599		122,599	6,122	128,721			32
33	Real Estate Taxes			9,791	9,791		9,791		9,791			33
34	Rent-Facility & Grounds							2,376	2,376			34
35	Rent-Equipment & Vehicles			4,554	4,554		4,554	361	4,915			35
36	Other (specify):*											36
37	**TOTAL Ownership**			174,756	174,756		174,756	14,086	188,842			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		32,715		32,715		32,715		32,715			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			37,230	37,230		37,230		37,230			42
43	Other (specify):* Nonallowable Costs			6,266	6,266		6,266	(6,266)				43
44	**TOTAL Special Cost Centers**		32,715	43,496	76,211		76,211	(6,266)	69,945			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	970,498	205,247	700,754	1,876,499		1,876,499	5,789	1,882,288			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

**** See schedule of adjustments attached at end of cost report.**

SEE ACCOUNTANTS' COMPILATION REPORT

Robings Manor Nursing Home
Provider # 0026716
12/31/2002

Schedule 5A

VI. Adjustment Detail
Line 29 - Other

Description	Amount	Schedule V Reference
Non-allowable PAC Dues		
Offset Meal Income		
Total		

See Accountants' Compilation Report

Facility Name & ID Number Robings Manor Nursing Home # 0026716 Report Period Beginning: 01/01/02 Ending: 12/31/02

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(2,903)	2		4
5	Telephone, TV & Radio in Resident Rooms	(2,876)	43		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(878)	30		9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(248)	43		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions	(589)	43		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(1,571)	43		24
25	Fund Raising, Advertising and Promotional	(982)	43		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule				29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (10,047)		$	30

OHF USE ONLY								
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	15,836		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 15,836		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ 5,789		37

*These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		x	$		38
39						39
40	Gift and Coffee Shops		x			40
41	Barber and Beauty Shops		x			41
42	Laboratory and Radiology		x			42
43	Prescription Drugs		x			43
44	Exceptional Care Program		x			44
45	Other-Attach Schedule		x			45
46	Other-Attach Schedule		x			46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

SEE ACCOUNTANTS' COMPILATION REPORT

Robings Manor Nursing Home

ID# 0026716

Report Period Beginning: 01/01/02

Ending: 12/31/02

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1		$		1
2				2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	0		49

STATE OF ILLINOIS — Summary A

Facility Name & ID Number Robings Manor Nursing Home # 0026716 Report Period Beginning: 01/01/02 Ending: 12/31/02

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(2,903)	0	0	0	0	0	0	0	0	0	0	(2,903)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	397	0	0	0	0	0	0	0	0	0	397	5
6	Maintenance	0	707	0	0	0	0	0	0	0	0	0	707	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(2,903)	1,104	0	0	0	0	0	0	0	0	0	(1,799)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	TOTAL Health Care and Programs	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	(39,181)	0	0	0	0	0	0	0	0	0	(39,181)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	8,690	0	0	0	0	0	0	0	0	0	8,690	19
20	Fees, Subscriptions & Promotions	0	531	0	0	0	0	0	0	0	0	0	531	20
21	Clerical & General Office Expenses	0	11,926	0	0	0	0	0	0	0	0	0	11,926	21
22	Employee Benefits & Payroll Taxes	0	13,604	0	0	0	0	0	0	0	0	0	13,604	22
23	Inservice Training & Education	0	441	0	0	0	0	0	0	0	0	0	441	23
24	Travel and Seminar	0	1,112	0	0	0	0	0	0	0	0	0	1,112	24
25	Other Admin. Staff Transportation	0	1,045	0	0	0	0	0	0	0	0	0	1,045	25
26	Insurance-Prop.Liab.Malpractice	0	1,600	0	0	0	0	0	0	0	0	0	1,600	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	TOTAL General Administration	0	(232)	0	0	0	0	0	0	0	0	0	(232)	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(2,903)	872	0	0	0	0	0	0	0	0	0	(2,031)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Robings Manor Nursing Home # 0026716 **Report Period Beginning:** 01/01/02 **Ending:** 12/31/02

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	(878)	6,105	0	0	0	0	0	0	0	0	0	5,227	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	6,122	0	0	0	0	0	0	0	0	0	6,122	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	2,376	0	0	0	0	0	0	0	0	2,376	34
35	Rent-Equipment & Vehicles	0	0	361	0	0	0	0	0	0	0	0	361	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	(878)	12,227	2,737	0	0	0	0	0	0	0	0	14,086	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	(6,266)	0	0	0	0	0	0	0	0	0	0	(6,266)	43
44	**TOTAL Special Cost Centers**	(6,266)	0	0	0	0	0	0	0	0	0	0	(6,266)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(10,047)	13,099	2,737	0	0	0	0	0	0	0	0	5,789	45

Facility Name & ID Number Robings Manor Nursing Home # 0026716 Report Period Beginning: 01/01/02 Ending: 12/31/02

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
James Petersen	See attached schedule 6B			See attached schedule 6B		
Mark Petersen	See attached schedule 6B			See attached schedule 6B		

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [x] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	5	Utilities	$	Petersen Health Care Companies	0.00%	$ 397	$ 397	1
2	V	6	Maintenance supplies		Petersen Health Care Companies	0.00%	707	707	2
3	V	17	Administrative	39,181	Petersen Health Care Companies	0.00%		(39,181)	3
4	V	19	Professional services		Petersen Health Care Companies	0.00%	8,690	8,690	4
5	V	20	Dues, subscriptions, fees		Petersen Health Care Companies	0.00%	531	531	5
6	V	21	Clerical & general office		Petersen Health Care Companies	0.00%	11,926	11,926	6
7	V	22	Employee benefits		Petersen Health Care Companies	0.00%	13,604	13,604	7
8	V	23	Inservice training & education		Petersen Health Care Companies	0.00%	441	441	8
9	V	24	Travel & seminar		Petersen Health Care Companies	0.00%	1,112	1,112	9
10	V	25	Other admin staff transportation		Petersen Health Care Companies	0.00%	1,045	1,045	10
11	V	26	Insurance - prop, liability, malp		Petersen Health Care Companies	0.00%	1,600	1,600	11
12	V	30	Depreciation		Petersen Health Care Companies	0.00%	6,105	6,105	12
13	V	32	Interest		Petersen Health Care Companies	0.00%	6,122	6,122	13
14	Total			$ 39,181			$ 52,280	$ * 13,099	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Robings Manor Nursing Home # 0026716 Report Period Beginning: 01/01/02 Ending: 12/31/02

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	34	Rent - facility and grounds	$	Petersen Health Care Companies	0.00%	$ 2,376	$ 2,376	15
16	V	35	Rent - equipment and vehicles		Petersen Health Care Companies	0.00%	361	361	16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 2,737	$ * 2,737	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Robings Manor Nursing Home
Provider # 0026716
12/31/2002
Schedule 6B
VII Related Parties-Page 6

Related Nursing Homes	City		Ownership %	1/1-8/30/02	8/31-12/31/02
Countryview Terrace	Louisville, IL				
Bement Health Care Center	Bement, IL		James Petersen	60%	0%
Sunset Manor Nursing Home	Canton, IL		Mark Petersen	40%	100%
Kewanee Care Home	Kewanee, IL				
Robings Manor Nursing Home	Brighton, IL				
Eastview Terrace	Sullivan, IL				
Havana Health Care Center	Havana, IL				
Arcola Health Care Center	Arcola, IL				
Palm Terrace of Mattoon	Mattoon, IL				
Prairie City Health Care Center	Prairie City, IL	* - not affiliated after 8/30/2002			
Out of State Nursing Homes					
Meadow Lawn Nursing Center	Davenport, IA				
Friendly Village	Rhinelander, WI	* - not affiliated after 8/30/2002			
Horizons Unlimited	Rhinelander, WI	* - not affiliated after 8/30/2002			
Taylor Park	Rhinelander, WI	* - not affiliated after 8/30/2002			
Passport	Rhinelander, WI	* - not affiliated after 8/30/2002			
Cumberland Heights-Tomahawk	Tomahawk, WI	* - not affiliated after 8/30/2002			
Maple Park	Rhinelander, WI	* - not affiliated after 8/30/2002			
Opportunities Unlimited (Workshop setup, no beds)					
Other Related Business Entities					
Petersen Health Care Companies	Peoria, IL	Management/ Bookkeeping			
Petersen Property	Canton, IL	Building-Sunset Manor			
Related Assisted Living					
Courtyard Estates	Kewanee, IL				

See Accountants' Compilation Report

Facility Name & ID Number Robings Manor Nursing Home # 0026716 Report Period Beginning: 01/01/02 Ending: 12/31/02

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week Hours	Percent	Compensation Included in Costs for this Reporting Period** Description	Amount	Schedule V. Line & Column Reference	
1	Mark Petersen	President	Administrative	**	112,141	5	10.00	Salary	$ 12,859	L17,C1	1
2	James Petersen	Ex-president	Administrative	**	300,538	5	10.00	Salary	34,462	L17, C1	2
3	Todd Petersen	Administrative	Administrative	**	61,042	5	10.00	Salary	7,000	L17, C1	3
4	Mark Petersen	Administrator	Administrative	**	113,038	5	10.00	Salary	12,962	L21, C1	4
5											5
6			** For ownership interest - see attached schedule 6B								6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 67,283		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Robings Manor Nursing Home
Provider # 0026716
12/31/2002

Schedule 7A

VII. Related Parties (continued)
C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.
Compensation Received From Other Nursing Homes

Name	Bement Health Care	Country View Terrace	Eastview Terrace	Arcola Health Care	Meadow Lawn Nursing	Palm Terrace of Mattoon	Sunset Manor	Kewanee Care Center	Havana Care Center	Prairie City	Total	Robings Manor	Grand Total
James Petersen	29,605	8,487	29,671	50,451	33,470	5,410	54,493	39,308	40,847	8,796	300,538	34,462	335,000
Mark Petersen	22,182	6,358	22,231	37,801	25,078	4,052	40,829	29,453	30,605	6,590	225,179	25,821	251,000
Todd Petersen	6,013	1,724	6,027	10,247	6,798	1,097	11,068	7,984	8,297	1,787	61,042	7,000	68,042
Total Compensation Received From Other Nursing Homes	57,800	16,569	57,929	98,499	65,346	10,559	106,390	76,745	79,749	17,173	586,759	67,283	654,042

See Accountants' Compilation Report

Facility Name & ID Number Robings Manor Nursing Home # 0026716 Report Period Beginning: 01/01/02 Ending: 12/31/02

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: Petersen Health Care Companies
Street Address: 7218 North Villa Lake
City / State / Zip Code: Peoria, IL 61614
Phone Number: (309) 691-8113
Fax Number: (309) 691-8622

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	5	Utilities	Patient Days	229,422	11	$ 3,858	$ 0	23,601	$ 397	1
2	6	Maintenance supplies	Patient Days	229,422	11	6,877	0	23,601	707	2
3	19	Professional services	Patient Days	229,422	11	84,471	0	23,601	8,690	3
4	20	Dues, subscriptions, fees	Patient Days	229,422	11	5,163	0	23,601	531	4
5	21	Clerical & general office exp	Patient Days	229,422	11	115,931	0	23,601	11,926	5
6	22	Employee benefits	Patient Days	229,422	11	132,243	0	23,601	13,604	6
7	23	Inservice training & education	Patient Days	229,422	11	4,287	0	23,601	441	7
8	24	Travel & seminar	Patient Days	229,422	11	10,813	0	23,601	1,112	8
9	25	Other admin straff transport.	Patient Days	229,422	11	10,154	0	23,601	1,045	9
10	26	Insurance - prop, liability, malp	Patient Days	229,422	11	15,558	0	23,601	1,600	10
11	30	Depreciation	Patient Days	229,422	11	59,343	0	23,601	6,105	11
12	32	Interest	Patient Days	229,422	11	59,511	0	23,601	6,122	12
13	34	Rent - grounds and facility	Patient Days	229,422	11	23,100	0	23,601	2,376	13
14	35	Rent - equipment	Patient Days	229,422	11	3,511	0	23,601	361	14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 534,820	$		$ 55,017	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Robings Manor Nursing Home # 0026716 Report Period Beginning: 01/01/02 Ending: 12/31/02

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related											
	Long-Term											
1	First Bank		x	Mortgage	$10,800.00	11/27/00	$ 1,020,000	$	9/1/04	0.0875	$ 46,912	1
2	Bank of Farmington		x	Purchase of Van	$761.65	08/10/99	45,000	15,233	08/10/04	0.0775	1,583	2
3	LaSalle National Bank		x	Mortgage	$ 2,206 + int	08/31/02	2,036,866	2,028,042	8/31/07	Variable	63,436	3
4												4
5												5
	Working Capital											
6	Peoples National Bank		x	Home Office Line of Credit				Interest only			7,282	6
7	LaSalle National Bank		x	Line of credit		8/31/02	176,718	176,718	8/31/03	Variable	2,284	7
8												8
9	TOTAL Facility Related				$11,561.65		$ 3,278,584	$ 2,219,993			$ 121,497	9
	B. Non-Facility Related*											
10								Amortization of Loan Costs			1,102	10
11								Home Office Allocation			6,122	11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$ 7,224	14
15	TOTALS (line 9+line14)						$ 3,278,584	$ 2,219,993			$ 128,721	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. **$** None **Line #** N/A

*** Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)**

SEE ACCOUNTANTS' COMPILATION REPORT

**** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)**

Facility Name & ID Number Robings Manor Nursing Home # 0026716 Report Period Beginning: 01/01/02 Ending: 12/31/02

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.

1. Real Estate Tax accrual used on 2001 report.		$ 8,885	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	2001	$ 9,338	2
3. Under or (over) accrual (line 2 minus line 1).		$ 453	3
4. Real Estate Tax accrual used for 2002 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 9,338	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**		$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)**		$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		$ 9,791	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	1997	8,107	8
	1998	8,726	9
	1999	8,581	10
	2000	8,886	11
	2001	9,338	12

Real estate tax accrual based on 100% of the prior year's tax bill.

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2001	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2001 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2001 real estate tax costs, as well as copies of your real estate tax bills for calendar 2001.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2001 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2002 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions,

2001 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Robings Manor Nursing Home COUNTY Macoupin

FACILITY IDPH LICENSE NUMBER 0026716

CONTACT PERSON REGARDING THIS REPORT Mark Petersen

TELEPHONE (309) 691-8113 FAX #: (309) 691-8622

A. **Summary of Real Estate Tax Cos**

Enter the tax index number and real estate tax assessed for 2001 on the lines provided below. Enter only the portion of tl cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursir home property which is vacant, rented to other organizations, or used for purposes other than long term care must not b entered in Column D. Do not include cost for any period other than calendar year 200l

	(A) Tax Index Numbe	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	21-001-047-00	Lot 12, Albro Palmers etal sub div	$ 4,142.00	$ 4,142.00
2.	21-001-048-00	N Pt Lot 13, Albro Palmers etal sub d	$ 5,196.00	$ 5,196.00
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 9,338.00	$ 9,338.00

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not direct used for nursing home services? _____ YES X NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing hom (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used

C. **Tax Bills**

Attach a copy of the 2001 tax bills which were listed in Section A to this statement. Be sure to use the 2001 tax bill whic is normally paid during 2002.

See Accountants' Compilation Report

Facility Name & ID Number Robings Manor Nursing Home # 0026716 Report Period Beginning: 01/01/02 Ending: 12/31/02

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 11,200 B. General Construction Type: Exterior Brick Frame Wood Number of Stories One

C. Does the Operating Entity? [x] (a) Own the Facility [ ] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.

D. Does the Operating Entity? [x] (a) Own the Equipment [x] (b) Rent equipment from a Related Organization. [x] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable)

None

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [x] NO
If so, please complete the following:

1. Total Amount Incurred: N/A
2. Number of Years Over Which it is Being Amortized: N/A
3. Current Period Amortization: N/A
4. Dates Incurred: N/A

Nature of Costs: N/A
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Resident Care	42,108	1977	$ 25,000	1
2					2
3	TOTALS	42,108		$ 25,000	3

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Robings Manor Nursing Home # 0026716 Report Period Beginning: 01/01/02 Ending: 12/31/02

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	68		1977	1977	$ 340,200	$ 1,240	25	$ 1,981	$ 741	$ 340,200	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Various			1978	357		20			357	9
10	Various			1979	62,800	2,512	25	2,512		60,288	10
11	Various			1983	27,383					27,383	11
12	Various			1984	3,788	66	20		(66)	3,788	12
13	Various			1985	4,563	192	20		(192)	4,689	13
14	Various			1989	6,368	202	20	318	116	5,279	14
15	Various			1991	5,525	175	20	276	101	3,697	15
16	Various			1992	14,285	454	20	714	261	7,628	16
17	Various			1995	18,999	534	20	950	416	6,805	17
18											18
19	Tile flooring			1996	991	25	20	50	25	350	19
20	Curtains			1996	3,187	284	20	159	(125)	1,047	20
21	Mini blinds			1996	358	32	20	18	(14)	119	21
22	Concrete parking lot			1996	1,250	74	20	63	(11)	404	22
23	Paving and lining parking lot			1996	8,325	494	20	416	(78)	2,531	23
24											24
25	Electrical box			1997	3,777	97	20	189	92	1,134	25
26	Medicare survey			1997	1,543		20	77	77	424	26
27	Windows			1997	1,640	42	20	82	40	451	27
28	Screen patio			1997	8,369	215	20	418	203	2,229	28
29	Seal coat parking lot			1997	675	60	20	34	(26)	179	29
30											30
31	Landscaping			1998	4,553	280	15	304	24	1,263	31
32	Remodeling			1998	1,822	47	20	91	44	410	32
33	Siding & windows			1998	39,885	1,023	20	1,994	971	8,973	33
34											34
35											35
36											36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete

See Page 12A, Line 70 for total

Facility Name & ID Number Robings Manor Nursing Home # 0026716 Report Period Beginning: 01/01/02 Ending: 12/31/02

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	Outdoor sign	1999	$ 1,036	$ 129	20	$ 52	$ (77)	$ 208	37
38	Sprinkler heads	1999	2,187	56	20	109	53	436	38
39	Handicapped bathrooms	1999	23,785	699	20	973	274	3,892	39
40	Nurse call system	1999	3,648	94	20	182	88	728	40
41									41
42	Roof	1999	21,735	557	20	1,087	530	4,348	42
43	Fencing	1999	2,777	214	20	139	(75)	556	43
44	Windows	1999	1,250	32	20	63	31	252	44
45									45
46	Garage & patio	1999	15,560	399	20	778	379	3,112	46
47									47
48	Windows	2000	1,233	32	20	62	30	155	48
49	Key system	2000	1,080	34	20	54	20	135	49
50	Resurface parking lot	2000	1,950	173	20	98	(75)	245	50
51									51
52	Kitchen remodeling	2001	2,152	55	20	108	53	162	52
53	Air compressor	2001	5,900	151	20	295	144	443	53
54	Carpet	2001	1,221	31	20	61	30	92	54
55	New roof - shed	2001	1,320	34	20	66	32	99	55
56	Remodel skill units	2001	5,897	151	20	295	144	442	56
57									57
58	Building upgrades	2002	4,937	121	20	123	2	123	58
59	Nurses station cabinets	2002	2,369	338	20	59	(279)	59	59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 660,680	$ 11,348		$ 15,250	$ 3,902	$ 495,114	70

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete

Facility Name & ID Number Robings Manor Nursing Home # 0026716 Report Period Beginning: 01/01/02 Ending: 12/31/02

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 135,005	$ 17,145	$ 12,854	$ (4,291)	10	$ 44,087	71
72	Current Year Purchases	11,553	4,621	673	(3,948)	10	673	72
73	Fully Depreciated Assets	98,890					98,890	73
74	Home office allocation			6,105	6,105			74
75	TOTALS	$ 245,448	$ 21,766	$ 19,632	$ (2,134)		$ 143,650	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Facility Van	89 Ford Van	1993	$ 10,795	$	$	$		$ 10,795	76
77	Facility Van	Hossler Van	1999	40,785	4,698	8,157	3,459		33,647	77
78										78
79										79
80	TOTALS			$ 51,580	$ 4,698	$ 8,157	$ 3,459		$ 44,442	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 982,708	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 37,812	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 43,039	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 5,227	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 683,206	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number Robings Manor Nursing Home # 0026716 Report Period Beginning: 01/01/02 Ending: 12/31/02

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5			Home Office Allocation		2,376			5
6								6
7	TOTAL				$ 2,376 **			7

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease .

9. Option to Buy: ☐ YES ☐ NO Terms: *

10. Effective dates of current rental agreement:
Beginning
Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2003	$
13.	/2004	$
14.	/2005	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☒ NO

16. Rental Amount for movable equipment: $ 4,915 Description: Dishwasher $767; Laundry equip $3,432; Nursing equip $355; Home office allocation $361
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18					18
19			N/A		19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Robings Manor Nursing Home # 0026716 Report Period Beginning: 01/01/02 Ending: 12/31/02

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? [ ] YES [X] NO

It is the policy of this facility to only hire certified nurses aides.

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
- IN-HOUSE PROGRAM [ ]
- IN OTHER FACILITY [ ]
- COMMUNITY COLLEGE [ ]
- HOURS PER AIDE ____

3. CLINICAL PORTION:
- IN-HOUSE PROGRAM [ ]
- IN OTHER FACILITY [ ]
- HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

SEE ACCOUNTANTS' COMPILATION REPORT

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	L10A, C3	hrs	$	1,025	$ 20,501	$	1,025	$ 20,501	1
2	Licensed Speech and Language Development Therapist	L10A, C3	hrs		674	17,781		674	17,781	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	L10A, C3	hrs		349	34,136		349	34,136	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	L39, C2	# of prescrpts				32,016		32,016	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify): See Schedule 16A						699		699	13
14	TOTAL			$	2,048	$ 72,418	$ 32,715	2,048	$ 105,133	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

SEE ACCOUNTANTS' COMPILATION REPORT

Robings Manor Nursing Home
Provider #: 0026716
01/01/02 to 12/31/02

Schedule 16A

XIV. Special Services
Line 13 Other (specify):

Service	Line Reference	Outside Practioner Units	Cost	Supplies
Laboratory	L39, C2			607
Radiology	L39, C2			92
Total			0	699

See Accountants' Compilation Report

Facility Name & ID Number Robings Manor Nursing Home # 0026716 Report Period Beginning: 01/01/02 Ending: 12/31/02

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/02 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 1,696,165	$ 1,696,165	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance None)	298,808	298,808	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	55,164	55,164	6
7	Other Prepaid Expenses	4,352	4,352	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): Due from owner	1,063,568	1,063,568	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 3,118,057	$ 3,118,057	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	42,621	25,000	13
14	Buildings, at Historical Cost	672,537	660,680	14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	299,294	297,028	16
17	Accumulated Depreciation (book methods)	(750,689)	(683,206)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 263,763	$ 299,502	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 3,381,820	$ 3,417,559	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 1,175,432	$ 1,175,432	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	176,718	176,718	29
30	Accrued Salaries Payable	36,751	36,751	30
31	Accrued Taxes Payable (excluding real estate taxes)	53	53	31
32	Accrued Real Estate Taxes(Sch.IX-B)	9,338	9,338	32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See Attached Schedule 17A	97,641	97,641	36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 1,495,933	$ 1,495,933	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	15,233	15,233	39
40	Mortgage Payable	2,028,042	2,028,042	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 2,043,275	$ 2,043,275	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 3,539,208	$ 3,539,208	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (157,388)	$ (121,649)	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 3,381,820	$ 3,417,559	48

SEE ACCOUNTANTS' COMPILATION REPORT

***(See instructions.)**

Robings Manor Nursing Home
Provider # 0026716
12/31/2002

Schedule 17A

XV. Balance Sheet

Line 36. Other Current Liabilities

	Operating	After Consolidation
Medicaid - Resident	54,702	54,702
Wages Garnishments	2,494	2,494
Accrued Insurance - General	37,921	37,921
Accrued Insurance - W/S	3,050	3,050
Accrued Expenses	(526)	(526)
Total	**97,641**	**97,641**

See Accountants' Compilation Report

Facility Name & ID Number Robings Manor Nursing Home # 0026716 Report Period Beginning: 01/01/02 Ending: 12/31/02

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 310,435	1
2	Restatements (describe):		2
3	**Prior period adjustment**	(900,315)	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (589,880)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	432,492	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 432,492	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ (157,388)	24 *

Operating Entity Only

*** This must agree with page 17, line 47.**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Robings Manor Nursing Home # 0026716 Report Period Beginning: 01/01/02 Ending: 12/31/02

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 2,168,944	1
2	Discounts and Allowances for all Levels	22,030	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 2,190,974	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	114,742	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 114,742	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals	2,903	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 2,903	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***		25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Transportation	372	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 372	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 2,308,991	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	383,565	31
32	Health Care	835,333	32
33	General Administration	406,634	33
	B. Capital Expense		
34	Ownership	174,756	34
	C. Ancillary Expense		
35	Special Cost Centers	38,981	35
36	Provider Participation Fee	37,230	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 1,876,499	40
41	**Income before Income Taxes (line 30 minus line 40)****	432,492	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 432,492	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? No If not, please attach a reconciliation.**
Entity files as a cash basis taxpayer.

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation. SEE ACCOUNTANTS' COMPILATION REPORT**

**** **Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number Robings Manor Nursing Home # 0026716 Report Period Beginning: 01/01/02 Ending: 12/31/02

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	2,553	2,553	$ 48,824	$ 19.12	1
2	Assistant Director of Nursing	1,592	1,592	28,365	17.82	2
3	Registered Nurses	4,404	4,890	81,072	16.58	3
4	Licensed Practical Nurses	7,819	8,198	107,297	13.09	4
5	Nurse Aides & Orderlies	34,310	35,540	300,356	8.45	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	1,758	1,930	18,367	9.52	8
9	Activity Director	2,075	2,091	16,488	7.89	9
10	Activity Assistants					10
11	Social Service Workers	4,128	4,128	29,940	7.25	11
12	Dietician					12
13	Food Service Supervisor	2,071	2,079	17,445	8.39	13
14	Head Cook					14
15	Cook Helpers/Assistants	10,133	10,648	67,942	6.38	15
16	Dishwashers					16
17	Maintenance Workers	2,472	2,472	24,618	9.96	17
18	Housekeepers	8,285	8,668	54,738	6.31	18
19	Laundry	5,893	5,931	32,268	5.44	19
20	Administrator	2,080	2,080	57,654	27.72	20
21	Assistant Administrator					21
22	Other Administrative	339	339	60,283	177.83	22
23	Office Manager					23
24	Clerical	1,334	1,339	24,841	18.55	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	91,246	94,478	$ 970,498 *	$ 10.27	34

SEE ACCOUNTANTS' COMPILATION REPORT

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant		$		35
36	Medical Director	Monthly	7,800	L9, C3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	825	L10, C3	39
40	Physical Therapy Consultant	643	37,318	L10A, C3	40
41	Occupational Therapy Consultant	530	30,766	L10A, C3	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	671	30,182	L10A, C3	43
44	Activity Consultant				44
45	Social Service Consultant	6	375	L12, C3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	1,850	$ 107,266		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$		50
51	Licensed Practical Nurses		N/A		51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)		$		53

Facility Name & ID Number Robings Manor Nursing Home # 0026716 Report Period Beginning: 01/01/02 Ending: 12/31/02

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Susan Shaw	Administrator	0%	$ 57,654
		**	
Home Office Allocations			
Mark Petersen	Administrative	**	25,821
James Petersen	Administrative	**	34,462
** See Schedule 6B			
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 117,937

B. Administrative - Other

Description	Amount
Management Fees (eliminated in column 7)	$ 39,181
TOTAL (agree to Schedule V, line 17, col. 3)	$ 39,181
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Bush, Snyder & Assoc	Legal	$ 674
Mary Albert-Frits	Legal	1,304
Ginoli & Co	Accounting	160
Altschuler Melvoin & Glasser	Accounting	950
American Express Tax & Bus Svce	Accounting	3,700
ADP	Payroll service	8,063
America Online	Computer services	299
LTC Solutions	Computer services	2,820
Ivans	Computer services	428
Other	Computer services	346
See attached Schedule 21A		
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 18,744

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 29,959
Unemployment Compensation Insurance	8,463
FICA Taxes	64,737
Employee Health Insurance	41,951
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
401 (k) Retirement Plan	560
Employee morale	6,076
Life Insurance	406
TOTAL (agree to Schedule V, line 22, col.8)	$ 152,152

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
N/A		
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 400
Advertising: Employee Recruitment	506
Health Care Worker Background Check	302
(Indicate # of checks performed 25)	
Illinois Health Care Assn dues	1,861
Miscellaneous dues	144
Miscellaneous licenses	103
Miscellaneous subscriptions	546
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 3,862

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	8,273
Home Office Allocation	1,112
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 9,385

* Attach copy of IMRF notifications

**See instructions.

SEE ACCOUNTANTS' COMPILATION REPORT

Robings Manor Nursing Home
Provider #: 0026716
01/01/02 to 12/31/02

Schedule 21A

XIX. SUPPORT SCHEDULE

C. Professional Services

Total (agree to Schedule V, line 19, column 3)	18,744
Allocated from Management Company	
Accounting	7,843
Legal	847
Total (agree to Schedule V, line 19, column 8)	27,434

See Accountants' Compilation Report

Facility Name & ID Number Robings Manor Nursing Home # 0026716 Report Period Beginning: 01/01/02 Ending: 12/31/02

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007
1			$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9							N/A						
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Robings Manor Nursing Home # 0026716 Report Period Beginning: 01/01/02 Ending: 12/31/02

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **No**

(2) Are there any dues to nursing home associations included on the cost report? **Yes**
If YES, give association name and amount. **Illinois Health Care Assn - $ 1,861**

(3) Did the nursing home make political contributions or payments to a politica
action organization? **Yes** If YES, have these costs
been properly adjusted out of the cost report? **Yes**

(4) Does the bed capacity of the building differ from the number of beds licensed at the
end of the fiscal year? **No** If YES, what is the capacity? **N/A**

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? **10 yrs**

(6) Indicate the total amount of both disposable and non-disposable diaper expense
and the location of this expense on Sch. V. $ **N/A** Line

(7) Have all costs reported on this form been determined using accounting procedures
consistent with prior reports? **Yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **No**
If YES, give effective date of lease. **N/A**

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for
Schedule VII)? YES NO **X** If YES, please indicate name of the facility,
IDPH license number of this related party and the date the present owners took over
N/A

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department
of Public Aid during this cost report period. $ **37,230**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V
for an individual employee? **No** If YES, attach an explanation of the allocation.

SEE ACCOUNTANTS' COMPILATION REPORT

(13) Have costs for all supplies and services which are of the type that can be billed to
the Department of Public Aid, in addition to the daily rate, been properly classified
in the Ancillary Section of Schedule V? **Yes**

(14) Is a portion of the building used for any function other than long term care services for
the patient census listed on page 2, Section B? **No** For example,
is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach
a schedule which explains how all related costs were allocated to these functions

(15) Indicate the cost of employee meals that has been reclassified to employee benefits
on Schedule V. $ **None** Has any meal income been offset against
related costs? **Yes** Indicate the amount. $ **2,903**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for
residents? **No** If YES, please indicate the amount of income earned from such a
program during this reporting period. $ **N/A**
c. What percent of all travel expense relates to transportation of nurses and patients? **0**
d. Have vehicle usage logs been maintained? **Adequate records have been maintained.**
e. Are all vehicles stored at the nursing home during the night and all other
times when not in use? **N/A**
f. Has the cost for commuting or other personal use of autos been adjusted
out of the cost report? **N/A**
g. Does the facility transport residents to and from day training? N/A
Indicate the amount of income earned from providing such
transportation during this reporting period. $ **N/A**

(17) Has an audit been performed by an independent certified public accounting firm? **Yes**
Firm Name: **Ginoli & Co** The instructions for the
cost report require that a copy of this audit be included with the cost report. Has this copy
been attached? **No** If no, please explain. **Audit in progress**

(18) Have all costs which do not relate to the provision of long term care been adjusted ou
out of Schedule V? **Yes**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services
performed been attached to this cost report? **Yes**
Attach invoices and a summary of services for all architect and appraisal fees.

RECONCILIATION REPORT **Robings Manor Nursing** **04:08 PM** **11/04/05**

ITEM	Value 1	Cond.	Value 2	Difference	RESULTS	COMPARE CEL	SUB-SCHED.	LINE NO.	COL. NO.	WITH CELL	SUB-SCHED.	LINE NO.	COL. NO.
Adjustment Detail	5,789	equal to	5,789	0	O.K.	Pg5 Z22	B.	37	1	Pg4 K29	N/A	45	7
Interest Expense	128,721	equal to	128,721	0	O.K.	Pg9 P34	A.	15	10	Pg4 L13	N/A	32	8
Real Estate Tax Expenses	9,791	equal to	9,791	0	O.K.	Pg10 W24	B.	5	N/A	Pg4 L14	N/A	33	8
Amortization exp. Pre-opening & org.	N/A	equal to	0	#VALUE!	#VALUE!	Pg11 I33	E.	3	N/A	Pg4 L12	N/A	31	8
Ownership Costs-Depreciation	43,039	equal to	43,039	0	O.K.	Pg13 Y28	E.	49	2	Pg4 L11	N/A	30	8
Rental Costs A	2,376	equal to	2,376	0	O.K.	Pg14 L20+N22	A.	7 + 8	4+N/A	Pg4 L15	N/A	34	8
Rental Costs B	4,915	equal to	4,915	0	O.K.	Pg14 J30+N40	B.+ C.	16+21	N/A+4	Pg4 L16	N/A	35	8
Nurse Aid Training Prog.	0	equal to	0	0	O.K.	Pg15 L36	B.	10	1	Pg3 L23	N/A	13	8
Special Serv.- Staff Wages		equal to		0	O.K.	Pg16 N32	N/A	14	3	Pg4 E22	N/A	39	1
Therapy Services	171,383	equal to	171,708	-325	FAILED	Pg16 Z12+Z14...	N/A;B	1-4;40-43	8;2	Pg3 H20	N/A	1Oa	4
Special Serv.- Supplies	32,715	equal to	#VALUE!	#VALUE!	#VALUE!	Pg16 V32	N/A	14	6	Pg4 F22 + Pg 3	N/A	39,10a	2
Income Stat. General Serv.	383,565	equal to	383,565	0	O.K.	Pg19 P11	N/A	31	2	Pg3 H16	N/A	8	4
Income Stat. Health Care	835,333	equal to	835,333	0	O.K.	Pg19 P12	N/A	32	2	Pg3 H26	N/A	16	4
Income Stat. Admininstation	406,634	equal to	406,634	0	O.K.	Pg19 P13	N/A	33	2	Pg3 H39	N/A	28	4
Income Stat. Ownership	174,756	equal to	174,756	0	O.K.	Pg19 P15	N/A	34	2	Pg4 H18	N/A	37	4
Income Stat. Special Cost Ctr	38,981	equal to	38,981	0	O.K.	Pg19 P17	N/A	35	2	Pg4 H21..H24+H	N/A	38to41+43	4
Income Stat. Prov. Partic.	37,230	equal to	37,230	0	O.K.	Pg19 P18	N/A	36	2	Pg4 H25	N/A	42	4
Staff- Nursing	584,281	equal to	584,281	0	O.K.	Pg20 K11..K15+	A.	1-5,24,25,27-30	3	Pg3 E19	N/A	10	1
Staff- Nurse aide Training	0	< or = to		0	O.K.	Pg20 K16	A.	6	3	Pg3 E23	N/A	13	1
Staff-Licensed Therapist	0	equal to		0	O.K.	Pg20 K17	A.	7	3	Pg4 E22	N/A	39	1
Staff- Activities	16,488	equal to	16,488	0	O.K.	Pg20 K19+K20	A.	9+10	3	Pg3 E21	N/A	11	1
Staff- Social Serv. Workers	29,940	equal to	29,940	0	O.K.	Pg20 K21	A.	11	3	Pg3 E22	N/A	12	1
Staff- Dietary	85,387	equal to	85,387	0	O.K.	Pg20 K22..K26	A.	16-Dec	3	Pg3 E9	N/A	1	1
Staff- Maintenance	24,618	equal to	24,618	0	O.K.	Pg20 K27	A.	17	3	Pg3 E14	N/A	6	1
Staff- Housekeeping	54,738	equal to	54,738	0	O.K.	Pg20 K28	A.	18	3	Pg3 E11	N/A	3	1
Staff- Laundry	32,268	equal to	32,268	0	O.K.	Pg20 K29	A.	19	3	Pg3 E12	N/A	4	1
Staff- Administrative	117,937	equal to	117,937	0	O.K.	Pg20 K30..K32	A.	20-22	3	Pg3 E28	N/A	17	1
Staff- Clerical	24,841	equal to	24,841	0	O.K.	Pg20 K33..K34	A.	23+24	3	Pg3 E32	N/A	21	1
Staff- Medical Director	0	equal to		0	O.K.	Pg20 K37	A.	27	3	Pg3 E18	N/A	9	1
Total Salaries And Wages	970,498	equal to	970,498	0	O.K.	Pg20 K44	A.	34	3	Pg4 E29	N/A	45	1
Dietary Consultant	0	< or = to		0	O.K.	Pg20 X12	B.	35	2	Pg3 G9	N/A	1	3
Medical Director	7,800	< or = to	7,800	0	O.K.	Pg20 X13	B.	36	2	Pg3 G18	N/A	9	3
Consultants & contractors	825	< or = to	825	0	O.K.	Pg20 X14..X16+	B. & C.	37to39 and 50to5	2	Pg3 G19	N/A	10	3
Activity Consultant	0	< or = to		0	O.K.	Pg20 X21	B.	44	2	Pg3 G21	N/A	11	3
Social Service Consultant	375	< or = to	375	0	O.K.	Pg20 X22	B.	45	2	Pg3 G22	N/A	12	3
Supp. Sched.- Admin. Salar.	117,937	equal to	117,937	0	O.K.	Pg21 I16	A.	N/A	N/A	Pg3 E28	N/A	17	1
Supp. Sched.- Admin. Other	39,181	equal to	39,181	0	O.K.	Pg21 I24	B.	N/A	N/A	Pg3 G28	N/A	17	3
Supp. Sched.- Prof. Serv.	18,744	equal to	18,744	0	O.K.	Pg21 I41	C.	N/A	N/A	Pg3 G30	N/A	19	3
Supp. Sched.- Benefit/Taxes	152,152	equal to	152,152	0	O.K.	Pg21 P22	D.	N/A	N/A	Pg3 L33	N/A	22	8
Supp. Sched.- Sched of dues..	3,862	equal to	3,862	0	O.K.	Pg21 V22	F.	N/A	N/A	Pg3 L31	N/A	20	8
Supp. Sched.- Sched. of trav	9,385	equal to	9,385	0	O.K.	Pg21 V41	G.	N/A	N/A	Pg3 L35	N/A	24	8
Gen. Info - Particip. Fees	37,230	equal to	37,230	0	O.K.	Pg23 I38	N/A	11	N/A	Pg4 G25	N/A	42	3
Gen. Info - Employee Meals	None	< or = to	13,604	#VALUE!	#VALUE!	Pg23 S16	N/A	16	N/A	Pg3 K33	N/A	2 & 22	7
Gen. Info - Employee Meals	None	equal to	0	#VALUE!	#VALUE!	Pg23 S16	N/A	16	N/A	Pg21 P12	D.	N/A	N/A
Nurse aide training	0	equal to		0	O.K.	Pg15 U29..U31	B.	3, 4 & 5	4	Pg3 E23	N/A	13	1
Days of medicare provided	1,332	equal to	1,332	0	O.K.	Pg2 AB29	K.	N/A	N/A	Pg2 J30	B.	8	4
Adjustment for related org. costs	15,836	equal to	15,836	0	O.K.	Pg5 Z18	B.	34	1	Pg6 to Pg 6I Y4(	B.	14	8
Total loan balance	2,219,993	equal to	2,219,993	0	O.K.	Pg9 L34	A.	15	7	Pg17 V13+V27..	N/A	29+39-41	2
Real estate tax accrual	9,338	equal to	9,338	0	O.K.	Pg10 W15	B.	4	N/A	Pg17 V17	N/A	32	2
Land	25,000	equal to	25,000	0	O.K.	Pg11 T43	A.	3	4	Pg17 K25	N/A	13	2
Building cost	660,680	equal to	660,680	0	O.K.	Pg12 to 12I L43	B.	36	4	Pg17 K26+K27	N/A	14 & 15	2
Equipment and vehicle cost	297,028	equal to	297,028	0	O.K.	Pg13 O22+L13	C.& D.	41 + 46	1 + 4	Pg17 K28	N/A	16	2
Accumulated depr.	683,206	equal to	683,206	0	O.K.	Pg13 Y30	E.	51	2	Pg17 K29	N/A	17	2
End of year equity	-157,388	equal to	-157,388	0	O.K.	Pg18 I33	N/A	24	1	Pg17 S39	N/A	47	1
Net income (loss)	432,492	equal to	432,492	0	O.K.	Pg18 I15	N/A	7	1	Pg19 P30	N/A	43	2
Unamortized deferred maint. cost	0	equal to		0	O.K.	Pg22 F31-J31..S	H.	20	3	Pg17 K30	N/A	18	2
Balance Sheet	3,381,820	equal to	3,381,820	0	O.K.	Pg17:H41		25	1	Pg17 S41	N/A	48	1

	Salaries	Supplies	Other	Total	Reclass-ifications	Reclassified Total	Adjustmen	Adjusted Total
1. Dietary	85,387	10,652	0	96,039	0	96,039	0	96,039
2. Food P	0	87,939	0	87,939	0	87,939	-2,903	85,036
3. Housek	54,738	9,528	0	64,266	0	64,266	0	64,266
4. Laundry	32,268	6,565	0	38,833	0	38,833	0	38,833
5. Heat ar	0	0	42,839	42,839	0	42,839	397	43,236
6. Mainter	24,618	28,965	66	53,649	0	53,649	707	54,356
7. Other (s	0	0	0	0	0	0	0	0
8. Total G	197,011	143,649	42,905	383,565	0	383,565	-1,799	381,766
9. Medical	0	0	7,800	7,800	0	7,800	0	7,800
10. Nursin	584,281	20,919	825	606,025	0	606,025	0	606,025
10a. Ther	0	0	171,708	171,708	0	171,708	0	171,708
11. Activit	16,488	2,651	0	19,139	0	19,139	0	19,139
12. Social	29,940	346	375	30,661	0	30,661	0	30,661
13. Nurse	0	0	0	0	0	0	0	0
14. Progra	0	0	0	0	0	0	0	0
15. Other	0	0	0	0	0	0	0	0
16. Total H	630,709	23,916	180,708	835,333	0	835,333	0	835,333
17. Admin	117,937	0	39,181	157,118	0	157,118	-39,181	117,937
18. Direct	0	0	0	0	0	0	0	0
19. Profes	0	0	18,744	18,744	0	18,744	8,690	27,434
20. Fees,	0	0	3,331	3,331	0	3,331	531	3,862
21. Clerica	24,841	4,967	12,778	42,586	0	42,586	11,926	54,512
22. Emplo	0	0	138,548	138,548	0	138,548	13,604	152,152
23. Inserv	0	0	65	65	0	65	441	506
24. Travel	0	0	8,273	8,273	0	8,273	1,112	9,385
25. Other	0	0	2,616	2,616	0	2,616	1,045	3,661
26. Insura	0	0	35,353	35,353	0	35,353	1,600	36,953
27. Other	0	0	0	0	0	0	0	0
28. Total (	142,778	4,967	258,889	406,634	0	406,634	-232	406,402
29. Total (	970,498	172,532	482,502	1,625,532	0	1,625,532	-2,031	1,623,501
30. Depre	0	0	37,812	37,812	0	37,812	5,227	43,039
31. Amorti	0	0	0	0	0	0	0	0
32. Interes	0	0	122,599	122,599	0	122,599	6,122	128,721
33. Real E	0	0	9,791	9,791	0	9,791	0	9,791
34. Rent -	0	0	0	0	0	0	2,376	2,376
35. Rent -	0	0	4,554	4,554	0	4,554	361	4,915
36. Other	0	0	0	0	0	0	0	0
37. Total (	0	0	174,756	174,756	0	174,756	14,086	188,842
38. Medica	0	0	0	0	0	0	0	0
39. Ancilla	0	32,715	0	32,715	0	32,715	0	32,715
40. Barbe	0	0	0	0	0	0	0	0
41. Coffee	0	0	0	0	0	0	0	0
42	0	0	37,230	37,230	0	37,230	0	37,230
43. Other	0	0	6,266	6,266	0	6,266	-6,266	0
44. Total S	0	32,715	43,496	76,211	0	76,211	-6,266	69,945
45. Grand	970,498	205,247	700,754	1,876,499	0	1,876,499	5,789	1,882,288

	Operating	After Consolidation
General Service Cost Center		
1. Cash on	1,696,165	1,696,165
2. Cash - F	0	0
3. Account	298,808	298,808
4. Supply I	0	0
5. Short-Te	0	0
6. Prepaid	55,164	55,164
7. Other Pr	4,352	4,352
8. Account	0	0
9. Other (s	1,063,568	1,063,568
10. Total c	3,118,057	3,118,057
LONG TERM ASSETS		
11. Long-T	0	0
12. Long-T	0	0
13. Land	42,621	25,000
14. Buildin	672,537	660,680
15. Leasel	0	0
16. Equipn	299,294	297,028
17. Accum	-750,689	-683,206
18. Deferre	0	0
19. Organi	0	0
20. Accum	0	0
21. Restric	0	0
22. Other l	0	0
23. other (s	0	0
24. Total L	263,763	299,502
25. Total A	3,381,820	3,417,559
CURRENT LIABILITIES		
26. Accour	1,175,432	1,175,432
27. Officer'	0	0
28. Accour	0	0
29. Short-T	176,718	176,718
30. Accrue	36,751	36,751
31. Accrue	53	53
32. Accrue	9,338	9,338
33. Accrue	0	0
34. Deferre	0	0
35. Federa	0	0
36. Other (	97,641	97,641
37. Other (	0	0
38. Total C	1,495,933	1,495,933
LONG TERM LIABILITES		
39.Long-T	15,233	15,233
40.Mortga	2,028,042	2,028,042
41.Bonds I	0	0
42.Deferre	0	0
43.Other L	0	0
44.Other L	0	0
45.Total Lo	2,043,275	2,043,275
46.Total Li	3,539,208	3,539,208
47.Total E	-157,388	-121,649
48.Total Li	3,381,820	3,417,559

		Balance per Medicaid Trial Balance
1.	Gross F	2,168,944
2.	Discour	22,030
	Subtota	2,190,974
4.	Day Ca	0
5.	Other C	0
6.	Therapy	114,742
7.	Oxygen	0
	Subtota	114,742
9.	Paymer	0
10.	Other	0
11.	Nurses	0
12.	Gift an	0
13.	Barber	0
14.	Non-P	2,903
15.	Teleph	0
16.	Rental	0
17.	Sale o	0
18.	Sale o	0
19.	Labora	0
20.	Radiol	0
21.	Other	0
22.	Laund	0
	Subtot	2,903
24.	Contril	0
25.	Interes	0
	Subtot-	
27.	Other	372
28.	Other	0
	Subtot	372
30.	Total F	2,308,991
31.	Gener	680,120
32.	Health	1,154,988
33.	Gener	668,561
34.	Owner	144,710
35.	Specia	60,174
35.	Provid	41,063
37.	Other	0
40.	Total E	2,749,616
41.	Incom	-440,625
42.	Incom	0
43.	Net In	-440,625

Page

Line 16 for mortgage insurance.